Home Care Professionals

THERAPY VISIT NOTE

☐ Physical ☐ Occupational ☐ Speech

Patient Name

Therapy Visit # _____ (optional per agency policy)

Combined Therapy Visit # _____ (optional per agency policy)

ASSESSMENT

VITAL SIGNS

T _____
P _____
R _____
B/P _____
Wt _____
☐ Standard Precautions Maintained

Comments

BEHAVIOR / MENTAL STATUS

☐ Alert/Oriented
☐ Anxious
☐ Willing to Learn/Improve
☐ Lethargic
☐ Apathetic
☐ Noncompliant
☐ Comatose
☐ Other _____

Comments

SKIN

☐ No Deficit ☐ Warm/Dry ☐ Cool/Clammy ☐ Turgor Adequate

Wound #1
Location _____
L W D
DRAINAGE Amt _____
Color _____ Odor _____
WOUND BED
Color _____
Tissue _____
Pain _____

Wound #2
Location _____
L W D
DRAINAGE Amt _____
Color _____ Odor _____
WOUND BED
Color _____
Tissue _____
Pain _____

☐ Alterations in skin that impact plan: define

Comments

PAIN

☐ See Additional Pain Assessment Documentation (per agency policy)
Refer to: _____

Frequency of Pain interfering with patient's activity or movement:
☐ 0 - Patient has no pain
☐ 1 - Patient has pain that does not interfere with activity or movement
☐ 2 - Less often than daily
☐ 3 - Daily, but not constantly
☐ 4 - All of the time

PAIN PROFILE Primary Site _____
Intensity: 0 1 (LOW) 2 3 4 5 6 7 8 9 10 (HIGH)
Current pain management & effectiveness: _____
☐ Pain Management Teaching to patient/family *(document below)*
Patient's pain goal: _____
Progress toward pain goal: _____

Comments

☐ Fall Precautions Maintained
Medication change since last visit? ☐ No ☐ Yes, Specify _____
Homebound? ☐ No ☐ Yes (if yes, reason) _____

INTERVENTIONS

TREATMENT

TEACHING

PATIENT RESPONSE TO TEACHING

Title of Teaching Tool used: _____ given to: ☐ Patient ☐ Caregiver ☐ Both
☐ Instruction ☐ Pt/Cg. Verbalized Understanding ☐ Pt/Cg. Return Demonstration

Home Therapy Program established? ☐ No ☐ Yes
Participation and follow through between visits is: ☐ Adequate ☐ Inadequate ☐ Not Applicable ☐ Other _____
Medical Equipment/Adaptive Devices/Supplies used this visit: _____

THERAPY/AIDE SUPERVISION (optional)

Present on this visit? ☐ Yes ☐ No
Report changes in patient status? ☐ Yes ☐ No
Following ☐ Care Plan / ☐ Plan of Care? ☐ Yes ☐ No
Patient satisfied with care? ☐ Yes ☐ No
Courteous and Polite? ☐ Yes ☐ No
Changes made to ☐ Care Plan / ☐ Plan of Care ☐ Yes ☐ No

Additional instructions given during visit? ☐ Yes ☐ No Signature: _____ Date: _____

MEASURABLE PROGRESS TO GOALS

Conferenced With: SN PT DT SLP MSS HHA (circle one) Name: _____
Regarding: _____

Physician Contacted Re: _____ Date/Time _____
Order Changes: _____
Plan For Next Visit: _____
Discharge Planning: _____

Update to Therapy Care Plan:
Problem: _____
Intervention: _____
Goal: _____

Therapist Signature & Title	Time In	Time Out	Date

Check one: ☐ G0151-PT ☐ G0157-PTA ☐ G0152-DT ☐ G0158-OTA ☐ G0153-ST

Patient Signature	Date

Signature Validates Visit Date and Time

WHITE – Medical Record **YELLOW** – Office/Home Chart

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